

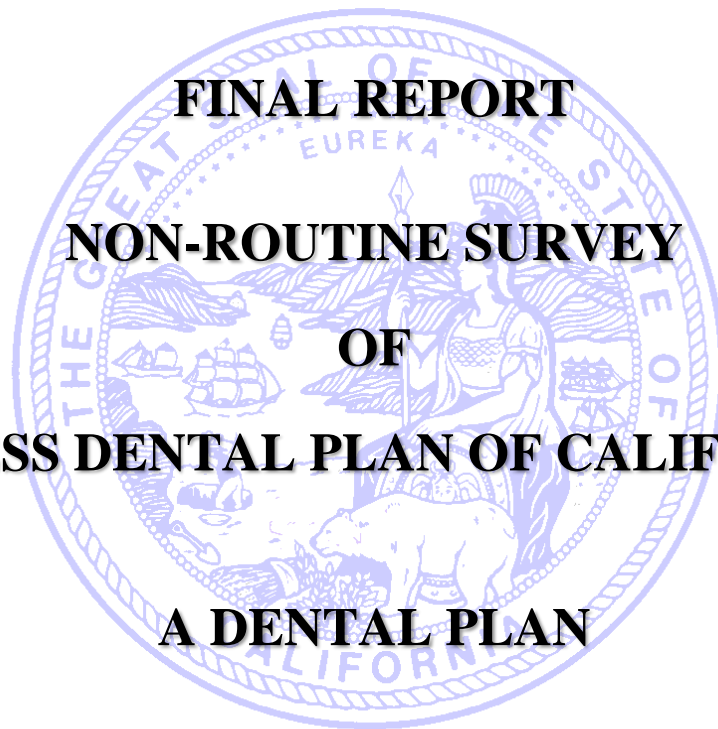


**DEPARTMENT OF MANAGED HEALTH CARE  
HELP CENTER  
DIVISION OF PLAN SURVEYS**

**AND THE**

**DEPARTMENT OF HEALTH CARE SERVICES  
MEDI-CAL DENTAL SERVICES DIVISION**

**FINAL REPORT  
NON-ROUTINE SURVEY  
OF  
ACCESS DENTAL PLAN OF CALIFORNIA  
A DENTAL PLAN**



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**Final Report of a Non-Routine Survey  
Access Dental Plan of California  
A Dental Plan  
January 4, 2013**

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## EXECUTIVE SUMMARY

In order to promote efficiency and avoid duplication of efforts, this Non-Routine Dental Survey of Access Dental Plan (“the Plan”) was conducted jointly by the Department of Managed Health Care (the “Department”) and the Department of Health Care Services (DHCS).

On March 9, 2012, the Department notified the Plan that a Non-Routine Dental Survey had commenced, and requested the Plan to submit information regarding its dental health delivery system. The survey team conducted the onsite portion of the survey from June 4, 2012, through June 6, 2012. The Department completed its investigatory phase and closed the survey on August 6, 2012.

## ISSUE BACKGROUND

The California Department of Health Care Services contracts with four Geographic Managed Care (GMC) plans to provide dental services to Medi-Cal members in Sacramento County.<sup>1</sup> The Department licenses the four GMC dental plans and is charged with enforcing the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the regulations issued under the authority of the Act.<sup>2</sup> Access Dental Plan has a contract with the DHCS to provide dental services to Sacramento GMC members and is licensed by the Department.

In February of 2012, the Department was alerted to several media reports alleging that children in the Denti-Cal Program, receiving care in Sacramento County, were not obtaining services in a timely manner and were not receiving the appropriate level and quality of care for their dental needs. It was reported that in fiscal year 2010-2011, only 30.6 percent of Sacramento County children enrolled in a contracted managed care plan saw a dentist, compared with nearly half of the children receiving fee-for-service Medi-Cal statewide.<sup>3</sup> Further, the articles alleged that children were experiencing long delays in receiving necessary dental care.<sup>4</sup>

Title 28, California Code of Regulations section 1300.82.1(a)(2) allows the Department to conduct a Non-Routine Survey for good cause under Section 1382(b) when the Director has reason to believe the Plan has violated Section 1370. The nature of the allegations in the media reports if true, were likely violations of numerous provisions of the Act, including Section 1370, and contrary to provisions and requirements of the DHCS GMC Contract.

The Department, in coordination with the DHCS, determined that both departments would conduct an investigation of all four GMC dental plans contracting with DHCS and licensed by the Department in order to assess the overall performance of the plans in providing dental care to

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<sup>1</sup> At the commencement of this Non-Routine Survey, the Department of Health Care Services contracted with five dental plans. However, as of June 1, 2011, Community Dental Services ceased operations and transferred enrollees to Liberty Dental Plan.

<sup>2</sup> The Knox-Keene Act is codified at Health and Safety Code section 1340 *et seq.* All references to “Section” are to the Health and Safety Code unless otherwise indicated. The regulations promulgated from the Knox-Keene Act are codified at Title 28 of the California Code of Regulations section 1000 *et seq.* All references to “Rule” are to Title 28 of the California Code of Regulations unless otherwise indicated.

<sup>3</sup> Wiener, Jocelyn. “Model? Dental Program Proves Painful for Kids.” *The Sacramento Bee* [Sacramento, CA] 12 Feb. 2012: 1A. <http://www.sacbee.com/2012/02/12/4256975/model-dental-program-proves-painful.html>

<sup>4</sup> Bazar, Emily. “State Health Chief Vows Changes to Sacramento County Dental Program.” *The Sacramento Bee* [Sacramento, CA] 24 Feb. 2012: 1B. <http://www.sacbee.com/2012/02/24/v-print/4287073/state-health-chief-vows-changes.html>

members. The review concentrated on the Plan's operational activities conducted for the time period of March 1, 2010, through February 29, 2012.

## SCOPE OF SURVEY

The Department conducted a focused review of the issues presented in the media reports. The review included an examination of the Plan's monitoring mechanisms for contracted providers, compiled encounter data, reports, policies, procedures, and standards in the following areas:

- Utilization Management
- Grievance and Appeals
- Timely Access to Care
- Quality of Care

The Department's review also included an assessment of the Plan's compliance with relevant provisions of the DHCS GMC Contract.

## SURVEY RESULTS

### DEFICIENCIES<sup>5</sup>

There were **three** Knox-Keene Act deficiencies identified during the Non-Routine Dental Survey.

**Deficiency #1: The Plan failed to address a known quality of care issue identified by the Plan's facility audit review.**

**Statutory/Regulatory/Contract Reference(s):** Section 1370; Rule 1300.70(a)(1); Rule 1300.70(a)(4)(D); Rule 1300.70(b)(1)(B); DHCS Contract 07-65802, Exhibit A, Attachment 4, Quality Improvement System, Item 1.

**Assessment:** The Department's review included an assessment of the Plan's ability to adequately monitor its provider network for potential quality of care issues. A review of the Plan's facility chart audits revealed that although the Plan identified that a facility failed a spore test for two consecutive years, Quality Management Committee minutes did not indicate that the Plan addressed the issue or that the Plan conducted appropriate follow-up. Rule 1300.70(b)(1)(B) requires that quality of care problems be identified and corrected for all provider entities.

**Health Care Impact:** Facility audits are intended to alert the Plan to possible quality of care issues occurring at the provider level. The Plan is required to identify, address and follow-up on known quality of care concerns. Failure to correct known concerns can affect the care provided to members. Spore testing is a way to ensure members are treated in a clean and sterile environment. Failure to provide care in a sterile environment can severely harm members.

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<sup>5</sup> Section I of this Report contains a discussion of these deficiencies.

**Deficiency #2: The Plan's Provider Manual and Specialty Referral Form contain language that has the potential of creating a provider financial disincentive for submitting specialty referrals to the Plan.**

**Statutory/Regulatory/Contract Reference(s):** Section 1367(g); Rule 1300.70(b)(1)(D); DHCS GMC Contract, Exhibit A, Attachment 1, Item 5; DHCS GMC Contract 07-65802, Exhibit A, Attachment 5, Item 1.

**Assessment:** The Plan's Provider Manual and Specialty Referral Form provide that if the Plan determines that a referral is not substantiated by sufficient documentation, the Plan will charge the provider the cost of the referral services. Although Plan representatives stated that providers are not charged for lack of documentation associated with a referral, the language in both the provider manual and on the Plan's Specialty Referral Form create a possibility that a provider will make a medical decision based on a personal fiscal impact in violation of Rule 1300.70(b)(1)(D).

**Health Care Impact:** The Plan should either revise or remove the language in both the Provider Manual and on the Specialty Referral Form in order to ensure that providers are not deterred in making medical decisions based on a financial impact.

**Deficiency #3: The Plan's provider to enrollee ratio exceeds 1:2000 and the Plan's methodology for member assignment does not take into account provider availability.**

**Statutory/Regulatory/Contract Reference(s):** Section 1367(e)(1); Rule 1300.67.2(d); Rule 1300.67.2.2(c)(1); 1300.67.2.2(d)(1); DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Items 1 and 3.

**Assessment:** A review of the Plan's Sacramento GMC member assignment revealed that 76% of members are assigned to one of the Plan's three contracted Access Dental Centers. An analysis of the member to provider ratio in each of the three Centers showed that the ratio greatly exceeds the ratio provided for in Rule 1300.67.2(d). Although the Plan filed an alternative mechanism in 1999 explaining that the Plan's ratio is but one factor in assessing provider capacity, the findings from this survey show that the Plan's methodology for assigning GMC members is not providing the Plan with an adequate assessment of provider capacity.

**Health Care Impact:** The Plan should ensure that it employs enough dentists to provide care to members. Further, the Plan should ensure that when members are assigned to one of the three Centers, the Plan takes into account the number of dentists in comparison to the number of total members assigned to the staff model. In addition, the Plan should ensure that it is aware of how much time each provider spends at each Center. By continuing to assign members to providers who already have more than 2000 assigned members, the Plan creates a high risk of timely access to care issues because members may not be able to see their providers within a reasonable time.

## RECOMMENDATIONS

The Department identified **one** recommendation during the current Non-Routine Dental Survey.

**Recommendation #1: The Plan should ensure that contracted Access Dental Centers appropriately and timely handle after-hours urgent and emergent calls.**

**Statutory/Regulatory/Contract Reference(s):** Section 1370; Rule 1300.70(a)(3); Rule 1300.70(b)(2)(G); Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(c)(9); Rule 1300.67.2.2(d)(1); DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Items 1, 3, and 13; DHCS GMC Contract 07-65802, Exhibit E, Attachment 1.

**Assessment:** The Plan has a contract with Access Dental Centers to provide dental health services to Sacramento GMC members. Access Dental Centers contract with Data Telesis as an after-hour telephone service. Review of onsite grievances showed that in one case, Data Telesis failed to call back a member resulting in a timely access to emergent care issue.

**Health Care Impact:** The Plan should ensure that Access Dental Centers are adequately monitoring Data Telesis. Members seeking after hours care are entitled to a prompt response from the provider's office. If calls are not handled timely, the member's dental health can be jeopardized.

## **CONTRACT FINDINGS**

The Department identified **three** Contract Findings:

**Contract Finding #1: During the review period, the Plan did not have a Member Education Policy that meets the DHCS GMC Member Education requirements.**

**Contract Reference(s):** DHCS GMC Contract 07-65802, Exhibit A, Attachment 10, Item 7.

**Assessment:** The DHCS GMC Contract 07-65802 requires that the Plan have a documented educational system for GMC members, and requires that the Plan conduct evaluations on the impact of educational programs and member behavior. Plan representatives stated that although the Plan had various education activities stated in the Plan's Member Education Policy, the activities were not necessarily directed at the Plan's GMC membership. The Plan also lacked a policy that specified how the Plan meets the requirements provided for in the DHCS GMC contract.

**Health Care Impact:** Member education assists members in understanding the importance of dental health. Targeted campaigns, informational material sent to members' homes and other types of outreach and education assist in providing members with information in making health care decisions and in receiving preventative care.

**Contract Finding #2: The Plan does not ensure that all written member information is provided to members at the sixth-grade reading level.**

**Contract Reference(s):** DHCS GMC Contract 07-65802, Exhibit A, Attachment 10, Item 7; DHCS GMC Contract 07-65802, Exhibit A, Attachment 13, Item 4-C.

**Assessment:** A review of Plan written material revealed that certain documents provided to GMC members contain language that is above the sixth-grade reading level. The DHCS GMC Contract 07-65802 requires that the Plan provide written material to members that is written at or below the sixth-grade reading level.

**Health Care Impact:** The Plan must ensure that it provides written information that is clear and easily understood. Letters that contain technical language may deny members the ability to make informed decisions regarding their dental care.

**Contract Finding #3: The Plan's Language Assistance Policy and Procedure explicitly excludes Medi-Cal enrollees and does not explain what Language Assistance services are available for Medi-Cal members.**

**Contract Reference(s):** DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Item 13.

**Assessment:** A review of the Plan's Language Assistance Policy and Procedure and Provider Manual revealed that the Policy and the Provider Manual instructing providers on the Plan's policy specifically exclude the Medi-Cal product line. The Plan does not have an additional Language Assistance policy that applies to Medi-Cal members.

**Health Care Impact:** The DHCS GMC Contract requires that the Plan ensure equal access to dental care for limited English proficient members through the provision of high quality interpreter and linguistic services. Although Plan representatives indicated that the Plan's general Language Assistance Policy does apply to Medi-Cal members, the language in the policy specifically excludes the Medi-Cal product line. Providers may believe that they are not required to seek language assistance for Medi-Cal members based on the language in the Plan's Provider Manual, which ultimately impacts the care received by limited or non-English speaking members.

### **PLAN'S EFFORTS TO ADDRESS DHCS IMMEDIATE ACTION ITEMS**

On March 7, 2012, the Director of the DHCS, Toby Douglas, sent a letter to the dental plans participating in the Sacramento GMC Program asking that the plans commit to increasing utilization and ensuring timely access to services. Access Dental responded by providing the following list of activities:

- **Beneficiary Letter:** The Plan developed a letter for all beneficiaries and completed the mailing campaign on March 16, 2012. The mailing process generated 1,398 calls and resulted in assistance in making appointments for 328 beneficiaries at provider offices. Subsequent to the Plan's initial mailing, the Plan completed a mailing campaign for members ages 0-5 on June 27, 2012. The Plan worked in collaboration with First 5, other dental plans and DHCS.
- **Phone Call Campaign:** The Plan completed calls to all beneficiaries. Further, the Plan repeated the calls made to members' families, with children ages 0-5 two additional times to reach families who did not respond to calls on the first try. Hundreds of additional appointments were made through the additional outreach phone call campaign. To

accomplish the call campaign, the Plan reassigned over ten additional staff members from other departments in addition to the regular call center staff.

- Issue Resolution Reporting: Access Dental submitted descriptions of its grievance resolution process, corrective action and related policies and procedures to DHCS. The Plan has also taken information received from the advocacy groups related to possible obstacles in receiving care for members. The information has been used to evaluate internal processes of the Plan and to make adjustments to operations such as streaming telephone numbers and contact information.
- Informational Flyer: The Plan worked with First 5, DHCS and other dental plans to create the flyer. The Plan mailed the informational flyer to members the week of June 25, 2012. The Plan also delivered the flyer in person to providers on July 5, 2012.
- Utilization: The Plan evaluated all provider locations for utilization levels. This process continues on a monthly basis and reports are delivered to DHCS. All provider locations have been visited multiple times since the beginning of the year to emphasize the importance of reaching identified thresholds. Provider locations that do not generate acceptable utilization have been counseled and in one incident, new membership assignment has been halted to a provider office pending further information in regards to improved utilization. All members who have not been treated in the past twelve months have been identified and attempts have been made by the Plan through the mailing campaign and outgoing calls. Members who are reached through the outreach campaign are requested to make an appointment with their provider locations. Thousands of appointments have been made for members through these outreach campaigns.
- Pay to Perform: Pay to Perform Capitation Programs have been implemented starting January 2012. Provider locations where utilization levels are at or above the required levels receive additional payments. The Plan also initiated a Pay for Performance supplemental fee schedule for targeted procedure codes, including all preventative services covered under the Denti-Cal Program. The Plan also monitors and provides counseling monthly to providers who underperform including follow-up. Providers not meeting the minimum monthly encounter submission will be subject to closure pending corrective action.
- Outreach to Federally Qualified Health Centers (FQHC): The Plan has identified all FQHC organizations in Sacramento and has initiated contracting with the entities. The Plan also developed special compensation programs that meet the operations of these organizations to incentivize the FQHCs to participate with the Plan.
- Timely Access Reports: The Plan developed written guidelines for missed appointment rescheduling and has distributed them to providers. The Plan also initiated follow-up with members who have expired specialist referrals to encourage the member to pursue treatment. The Plan also provides additional reports to DHCS in regards to availability of appointments by location for routine, preventative and emergency appointments. Reports regarding interpreter services and after-hours availability are submitted to DHCS. In order to increase provider locations the Plan undertook an evaluation of provider ability



in the provider panel, and developed strategies in increasing provider locations in targeted areas.

- Educational Seminars: The Plan designated a full time provider relations representative to its Medi-Cal Programs in 2012. The representative maintains regular contacts with all provider locations in continuously reinforcing the guidelines of the Program and to provide counseling to provider locations. The Plan developed a Frequently Asked Questions Guide and Quick Reference Guide for providers. The Plan also developed a training webinar for providers.
- Increased Provider and Specialist Enrollment: The Plan reached out to 25 Primary Care Dentists and 5 specialist locations. 9 providers agreed to join the Plan.

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A DENTAL HEALTH PLAN**

**SURVEY OVERVIEW**

The Department evaluates each health care service plan licensed pursuant to the Act. As authorized by Section 1380(c) of the Act, surveys performed pursuant to this section shall be conducted as often as deemed necessary by the Director to assure the protection of subscribers and enrollees.

This Non-Routine survey was limited to a review of the four managed dental care plans that have contracts with DHCS to provide dental services to Denti-Cal enrollees in Sacramento County. The Department's review was limited to the issues presented in media reports. The Department evaluated the Plan's monitoring mechanisms for contracted providers, compiled encounter data, reports, policies, procedures, and standards in the following areas:

**Utilization Management** – How the Plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.

**Grievance and Appeals** – The Plan is required to have compliant processes for resolving Member complaint/grievances in a professional, fair, and expeditious manner.

**Timely Access to Care** – The Plan is required to ensure that its services are accessible and available to GMC enrollees throughout its Sacramento service area and within reasonable timeframes. The Plan is required to monitor Primary Dentist assignment.

**Quality Management** – The Plan is required to assess and improve the quality of care it provides to enrollees.

The Department's review also encompassed relevant DHCS GMC contract provisions including but not limited to: Quality Management, Member Rights, Access and Availability, Utilization Management and Member Education.

The Preliminary Report was issued to the Plan on October 25, 2012. The Plan had 45 days to file a written statement with the Director identifying the deficiency and describing the action taken to correct the deficiency and the results of such action. The Plan has an opportunity to review the Final Report and file a response with the Department prior to the Department issuing the Final Report and making the Final Report public.

This Final Report addresses the Non-Routine Survey of the Plan, which commenced on March 9, 2012, and closed on August 6, 2012.

### **PLAN BACKGROUND**

Access Dental Plan is a for-profit network-model incorporated in 1993, and headquartered in Sacramento, CA. The Company is wholly owned by the Abbaszadeh Dental Group, Inc. (“ADG”). ADG is owned by Dr. Mohammed Reza Abbaszadeh. The Plan’s parent company owns Access Dental Centers. The Centers provide dental care for Plan members. The Plan also contracts with non-affiliated dental clinics throughout the Sacramento GMC service area.

Access Dental Centers began operating in 1989 and primarily served Sacramento County’s Dental Medi-Cal members. The Plan received its Knox-Keene license on December 22, 1993, and was one of the first Sacramento Dental GMC Plans. Over the years, the Plan included State Children’s Health Insurance Program and Healthy Families into its line of business. In 2008, the Plan expanded its operation to include commercial products.

As of August 2012, the Department of Health Care Services reported that 52,760 GMC members were assigned to the Plan; 34,124 of those members were between 0-20 years old.

## SECTION I: DISCUSSION OF DEFICIENCIES AND CURRENT STATUS

Within the scope of this Non-Routine Dental Survey, the Department identified **three** Knox-Keene Act deficiencies in the Plan's operations. The Plan received a Preliminary Report regarding these deficiencies. In that report, the Plan was instructed to:

- (a) Develop and Implement a corrective action plan for each deficiency, and
- (b) Provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions.

### 2012 SURVEY DEFICIENCIES

#	DEFICIENCY STATEMENT	STATUS
<b>QUALITY MANAGEMENT</b>		
<b>1</b>	<b>The Plan failed to address a known quality of care issue identified by the Plan's facility audit review.</b> (Section 1370; Rule 1300.70(a)(1); Rule 1300.70(a)(4)(D); Rule 1300.70(b)(1)(B); DHCS Contract 07-65802, Exhibit A, Attachment 4, Quality Improvement System, Item 1.)	<b>Not Corrected</b>
<b>2</b>	<b>The Plan's Provider Manual and Specialty Referral Form contain language that has the potential of creating a provider financial disincentive for submitting specialty referrals to the Plan.</b> (Section 1367(g); Rule 1300.70(b)(1)(D); DHCS GMC Contract, Exhibit A, Attachment 1, Item 5; DHCS GMC Contract 07-65802, Exhibit A, Attachment 5, Item 1.)	<b>Corrected</b>
<b>ACCESS AND AVAILABILITY OF SERVICES</b>		
<b>3</b>	<b>The Plan's provider to enrollee ratio exceeds 1:2000 and the Plan's methodology for member assignment does not take into account provider availability.</b> (Section 1367(e)(1); Rule 1300.67.2(d); Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(d)(1); DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Items 1 and 3.)	<b>Corrected</b>

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

## **DEFICIENCIES**

### **QUALITY MANAGEMENT**

**Deficiency #1: The Plan failed to address a known quality of care issue identified by the Plan's facility audit review.**

**Statutory/Regulatory/Contract Reference(s):** Section 1370; Rule 1300.70(a)(1); Rule 1300.70(a)(4)(D); Rule 1300.70(b)(1)(B); DHCS Contract 07-65802, Exhibit A, Attachment 4, Quality Improvement System, Item 1.

**Assessment:** The Department's review included an assessment of the level of activity by the Plan's Quality Assessment Program and its effectiveness in identifying and correcting deficiencies in care in accordance with Rule 1300.70(a)(4)(D). During the reporting period, the Plan monitored its contracted facilities and providers annually. One of the purposes of the audits according to the Plan's description of its Quality Management Program was to identify potential quality issues, investigate the issues, and report the issues to the Quality Management Committee for recommended action and follow-up. A focus area of the Plan's audit included Infection Control encompassing the following areas of review: cleaning and sterilization methods, agents and schedules, maintenance of autoclave, spore testing and storage of sterile packets. The results of the facility's performance are tracked in chart audits. The Department reviewed chart audits for the site facilities. One particular audit of the Plan's contracted Access Dental Facility in Sacramento revealed that the office failed 5 out of 52 weekly sterilizer spore tests in 2011. The notes in the chart audit noted that the facility had failed more than 5 times in the prior year. Although the facility failed an infection control test used to determine and evaluate the safety and cleanliness of the facility, a review of the Quality Improvement Committee minutes showed that the issue was not discussed and a corrective action plan for the provider or the facility was not implemented.

Section 1370 requires that every Plan establish procedures in accordance with Department regulations for continuously reviewing quality of care. Rule 1300.70(a)(1) requires the Plan to document the quality of care that is being reviewed, that problems are identified and that effective action is taken to improve care, and that follow-up is planned where indicated. In addition, Rule 1300.70(b)(1)(B) requires that quality of care problems be identified and corrected for all provider entities. Here, there was no indication in any of the Quality Improvement Committee minutes that the Plan addressed the issue identified by the Plan's audit in either the committee minutes for the year 2010 or 2011, even though the auditor's notes indicated that the spore testing issue was reoccurring for the same facility. There was no indication that the Plan took any action to monitor the problem or ensure that it did not occur again.

**Process or System Deficiencies That Need to be Addressed<sup>6</sup>:** The Plan should ensure that when quality of care issues are identified by the Plan's monitoring mechanisms, the Plan

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<sup>6</sup> This guidance is offered only as preliminary discussion points for the Plan to consider when determining its corrective actions for this deficiency. Corrective actions based solely on following this guidance may not necessarily correct the deficiency.

appropriately addresses the issue and conducts appropriate follow-up. Proper infection control is essential in ensuring facility cleanliness and ensuring members receive optimal care.

**Plan's Compliance Effort:** The Plan stated that it has a Facility and Chart Reviews policy and procedure to provide a consistent process for conducting facility and chart reviews of network provider offices and a mechanism for identifying quality of care issues in dental care delivery.

The Plan stated in its response that it does follow up on identified quality of care issues during onsite audits for all provider offices with no exception. An audit report identifying the deficiencies is sent to providers requiring a response with a corrective action. As required, an acknowledgment response with a corrective action plan is implemented by the office, and a verification of the implementation is verified on the next audit that is conducted as a follow-up.

The Plan responded that the office where the issue was identified did in fact acknowledge the deficiency, implemented a corrective action, and the Plan verified that the implementation was successful to completely resolve the issue shown in the 2012 Audit Report. The Results of the audit for the office were a solid 96% and 97% successful, however, it was noted on the 2010 audit that this office had 5 failed spore test results over the previous 52 weeks, but on the 2012 audit there were no positive results thus showing that the office had resolved that issue. The Plan submitted additional documentation showing the identified issue was addressed and a corrective action was requested by the Plan. The Plan also submitted the facility's acknowledgement that included the corrective action plan. In addition, the Plan submitted an excerpt from the Quality Management Committee (QMC) meeting materials that included discussion of results from Chart and Facility Audits and the 2011 Annual Evaluation Report that is submitted to the QMC for review.

The Plan submitted revised policies and procedures to include that the Plan is to provide a summary of corrective action in the quarterly audit report that is submitted to the QMC. The policy will be submitted to the QMC during the fourth quarter meeting (12/14/12) for approval and will be then submitted to the DMHC for approval. Upon DMHC approval, the policy will be implemented with an anticipated date of January 2013. The summary of corrective actions for any identified quality issues will be summarized in the first QMC meeting to be held in the first quarter of 2013.

#### **Department's Finding Concerning Plan's Compliance Effort:**

#### **STATUS: NOT CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this deficiency has not been fully corrected.

Although the Plan has revised its policy to include a summary of corrective actions for identified provider and facility issues in QMC meeting minutes, implementation has not occurred (as of this report). The Department will review the Plan's first quarter meeting minutes of 2013 to ensure that the new policy and procedure has been fully implemented and will correct the deficiency upon review.

**Deficiency #2: The Plan's Provider Manual and Specialty Referral Form contain language that has the potential of creating a provider financial disincentive for submitting specialty referrals to the Plan.**

**Statutory/Regulatory/Contract Reference(s):** Section 1367(g); Rule 1300.70(b)(1)(D); DHCS GMC Contract 07-65802, Exhibit A, Attachment 1, Item 5; DHCS GMC Contract 07-65802, Exhibit A, Attachment 5, Item 1.

**Assessment:** The Department's review included an assessment of the Plan's process for informing Plan contracted providers of the Plan's policies and procedures. The Plan provided the Department with its Provider Manual titled, "Access Dental Provider Manual." Chapter 6, Page 1 states the Plan's policy for specialty referrals and contains the following bolded language:

***"If the written referral request and supporting documentation does not substantiate the need for a referral, Access will charge the cost of the referral services back to the referring provider."***

In addition, the language above is included on the Plan's Specialty Referral Form which is included in the Plan's Provider Manual.

Section 1367(g) provides that the Plan demonstrate to the Department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. Rule 1300.70(b)(1)(D) requires that the Plan ensure appropriate care is not withheld or delayed for any reason including a financial gain and/or incentive to Plan providers. The language contained in both the Provider Manual and the Specialist Referral Form notifies the provider of the potential of being charged for a referral if the Plan determines that the referral was not substantiated by documentation. Creating the possibility that a provider may be charged for services if the Plan determines the services are not required can potentially create a financial disincentive for providers in referring patients for specialty care.

**Process or System Deficiencies That Need to be Addressed<sup>7</sup>:** The Plan should ensure that it provides clear direction on the documentation that is needed in order for the Plan to make a specialty referral decision so that providers know and understand the Plan's criteria for required documentation. The Plan should also revise the language in the Provider Manual and on the

Specialist Referral form to ensure that the language does not create a financial disincentive to providers for referral services.

**Plan's Compliance Effort:** The Plan, in collaboration with all the GMC/PHP dental plans has developed a standardized specialist referral form in an effort to create a more efficient, uniform and accessible specialty referral process that will enhance the member and provider experience for the GMC/PHP Program. With the standardized referral form, the language identified in the deficiency, will not be included in the referral form. The standardized referral form is scheduled

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<sup>7</sup> This guidance is offered only as preliminary discussion points for the Plan to consider when determining its corrective actions for this deficiency. Corrective actions based solely on following this guidance may not necessarily correct the deficiency.

to be finalized and implemented in January of 2013. The Plan stated that in the interim, it would remove the language noted in the deficiency from the current referral form.

### **Department's Finding Concerning Plan's Compliance Effort:**

#### **STATUS: CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that the deficiency has been fully corrected.

The Plan submitted both a revised referral form and a revised provider manual that omits the language cited in the deficiency.

## **ACCESS AND AVAILABILITY OF SERVICES**

**Deficiency #3: The Plan's provider to enrollee ratio exceeds 1:2000 and the Plan's methodology for member assignment does not take into account provider availability.**

**Statutory/Regulatory/Contract Reference(s):** Section 1367(e)(1); Rule 1300.67.2(d); Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(d)(1); DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Items 1 and 3.

**Assessment:** The Department's assessment included an evaluation of the Plan's Sacramento GMC member enrollment in comparison to the Plan's contracted providers in the area. Onsite interviews and document review showed that if a member has not selected a Primary Care Dentist upon enrollment, the Plan auto assigns the member to the closest geographical provider location based on the member's residence. The Department's review found that 39,427 members or over 76% of the Plan's Sacramento GMC membership are assigned to one of the Plan's three contracted Access Dental Centers. The Centers employ 12.5 dentists. In addition, 11,924 members or 23.2% of the Plan's GMC enrollment are assigned to other contracted network providers in the area.

Considering that the majority of the Sacramento GMC Sacramento members are assigned to one of the three Centers, the Department focused its review on the provider to member ratio in each of the three Centers. The review found that the provider to member ratio in each Center greatly exceeds the ratio standard provided for in Rule 1300.67.2(d).<sup>8</sup>

Rule 1300.67.2(d) provides that the ratio of enrollees to staff be reasonable as to assure that all services of the Plan be accessible to members on an appropriate basis without delays detrimental to the health of the enrollee. The Rule further provides that one full-time equivalent primary care physician be available for each two thousand enrollees or an alternative mechanism be

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<sup>8</sup> Access Dental Center, 2693 Florin Rd. Sacramento, CA; enrollee to provider ratio 1:3241  
Access Dental Center, 3945 Marysville Blvd. 1 and 2, enrollee to provider ratio: 1:3519  
Access Dental Center, 5200 Stockton Blvd: enrollee to provider ratio 1:2957. Plan representatives indicated that the ratios in the three facilities include enrollees over the age of 21 who the Plan counts as one fourth of a member considering benefits for enrollees over the age of 21 are limited.



provided by the Plan to demonstrate an adequate ratio. The DHCS GMC Contract requires that the Plan establish acceptable accessibility standards in accordance with Rule 1300.67.2.

The Plan submitted documentation showing that in 1999, in response to an Access and Availability finding made by the Department of Corporations in a Preliminary Report issued to the Plan, the Plan explained that its ratio of 1:3500 is one factor among other methods used to determine provider capacity. Although the Plan provided this alternative mechanism explanation in 1999, the findings from the current survey raise serious concerns regarding the Plan's ability to ensure accessibility for GMC members.

The Plan's methodology for member assignment calculates enrollment capacity by counting each provider at the Centers as one full-time equivalent. However, the Plan's methodology does not account for each provider's hours of availability nor does the Plan's methodology take into account whether or not the provider practices at other Centers or locations or sees other members in addition to GMC members. For example, a review of the enrollment for three different providers revealed that one provider was listed at three different locations with a total assignment of 8,492 members. Two other providers work part-time at two different locations yet are assigned over 3,000 members at only one location.

In addition, for the reporting period, the Plan had a total of 20 grievances concerning Sacramento GMC members. Out of the 20 grievances, 61.5% were related to issues with accessibility of services including appointment wait times. For example, in one case, the parent of a 12-year old member reported arriving at an appointment at the Marysville Boulevard clinic and waiting over one hour for an appointment. In another case, a parent reported waiting over two hours for their child to be seen.

The Department requires that if a Plan adheres to a provider to enrollee ratio that exceeds 1:2000, the Plan must file an alternative mechanism demonstrating an adequate ratio of enrollees to providers in accordance with Rule 1300.67.2(d). Here, although the Plan filed an alternative mechanism 13 years ago, the concentration of the majority of GMC Sacramento members into the Plan's contracted Centers and the Plan's failure to account for the time spent by each provider in each facility or to account for the total number of enrollees from other product lines assigned to the provider, require the Plan to further explain to the Department how it adequately monitored the Centers during the reporting period, and how it will actively monitor access and availability for GMC members going forward.

**Process or System Deficiencies That Need to be Addressed:** The Plan should file an alternative mechanism demonstrating to the Department how its ratio of 1:3500 is adequate to ensure appointment availability for Sacramento GMC members. The Plan's alternative mechanism was filed 13 years ago and may not be sufficient or adequate in providing adequate accessibility for members. Although the Plan does have accessibility monitoring in place, it is unclear whether those mechanisms are sufficient, or were sufficient during the reporting period, to ensure accessibility within the Centers. Further, the Plan should reevaluate its methodology for calculating provider to enrollee ratios to ensure it accounts for the time spent by providers in each Center or location.

**Plan's Compliance Effort:** The Plan's response stated that within the existing Sacramento County GMC Program, the Plan has operated on an approved alternative provider/member ratio

of 1 primary care dentist full time equivalent per 3500 members. The Plan has used this approved alternative provider to member ratio as a threshold by which provider capacity is monitored.

The Plan further stated that although the Plan intends to maintain the approved alternative ratio currently in place, in an effort to not impose perceived barriers to care, the Plan is transitioning to a ratio of 1 full time equivalent primary care dentist per 2000 enrollees for the Medi-Cal membership.

Through a structured implementation plan, the Plan has been incrementally reducing the number of members assigned to providers who exceed the 1:2000 membership ratios for GMC. On a monthly basis, the Plan has been assigning new members to offices that indicate the capacity is open to new members. The Plan has also identified existing members who have not received care in the last 12 months and is reassigning members to offices that can accept additional capacity. The Plan ensures that all assignments are compliant with accessibility standards and that all members are given 30 days notice of the change in assignment and their ability to contact the Plan to select a different primary care dentist at any time. As of 12/1/2012, all of the Plan's GMC providers are within the 1:2000 ratios.

The Plan stated that it has been actively recruiting dental providers in the Sacramento County GMC Program for most of 2012, to ensure capacity is equitably distributed within the Plan's GMC Program network.

The Plan submitted a newly developed policy and procedure denoting the methodology for monitoring dentist to member ratio as follows:

- The Plan monitors the number of members that are assigned to primary care dentists and/or facilities through system generated standard reports on a monthly basis.
- The Plan monitors availability of appointments and services for members in all geographic areas and initiates recruitment as needed to ensure provider capacity.
- Ongoing monitoring is conducted by Provider Services and Provider Relations to ensure that provider/member ratio standards are at levels that a participating dentist's office can absorb based on enrollment capacity factors.
- Auto-assignment processes generally assign all new patients to the designated primary dentist at any facility. Manual intervention is required prior to monthly roster preparation to redistribute members among the primary care dentists practicing within the facility based on the ratio objectives. This process is monitored closely by the Provider Relations and Provider Services teams to ensure that dentist to member ratios are maintained.
- Provider Relations verifies the number of practicing dentists and hours of availability during onsite visits to assure that data is based on actual employment levels and hours of work at the dental offices.
- Participating dentists and facilities are required to notify Access Dental immediately of any change in hour of availability of participating dentists within the facility.
- Participating primary care dentists and or facilities are closed to new members in the event that the primary care dentist to member ratio exceeds the target ratio.
- The Plan contracts with a complete panel of dental specialists, including oral surgeons, pedodontists, periodontists, endodontists, and orthodontists to ensure that overall member to dentist ratios are met and access standards are maintained.

- As necessary, Provider Relations initiates recruitment to maintain the availability of provider/facility choices for members.

The Plan stated that it will monitor compliance as follows:

- Provider accessibility standards shall be accessed annually and updated when applicable.
- Evaluation of the geographic distribution and adequacy of the primary care and specialty network shall be conducted quarterly, using industry standard software.
- Results of network adequacy studies shall be used to identify and analyze any gaps in the network. When gaps are identified, efforts shall be made to recruit and credential additional providers.
- Results of network adequacy studies shall be included quarterly and in annual reports to the Quality Management Committee.

**Department's Finding Concerning Plan's Compliance Effort:**

**STATUS: CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this deficiency has been fully corrected.

The Plan provided the Department with a current roster of contracted providers in the Plan's GMC network. The roster shows that as of December 1, 2012, all providers are assigned less than 2000 children enrollees. Therefore, the Department finds that this deficiency is corrected.

## **SECTION II: DISCUSSION OF RECOMMENDATIONS AND CURRENT STATUS**

In accordance with Section 1380(g), Department analysts offer advice and assistance to the Plan in the form of recommendations. Although a response to identified recommendations is not statutorily required, it is highly advised. These recommendations are not a statement of current Plan deficiencies. Recommendations are intended to alert the Plan to weaknesses in its operations or systems that have the potential to become deficiencies in the future. The Plan should review and evaluate recommendations, and take action as appropriate.

### **ACCESS AND AVAILABILITY OF SERVICES**

**Recommendation #1: The Plan should ensure that its contracted Access Dental Centers appropriately and timely handle after-hours urgent and emergent calls.**

**Statutory/Regulatory/Contract Reference(s):** Section 1370; Rule 1300.70(a)(3); Rule 1300.70(b)(2)(G); Rule 1300.67.2.2(c)(1); Rule 1300.67.2.2(c)(9); Rule 1300.67.2.2(d)(1); DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Items 1, 3, 10 and 13; DHCS GMC Contract 07-65802, Exhibit E, Attachment 1.

**Assessment:** The Plan's contracted Access Dental Centers have agreements with the telephone answering service, Data Telesis<sup>9</sup>, to answer urgent and emergent calls after normal business hours. The Department's review of grievance files revealed a case in which a GMC member called an Access Dental Center after-hours regarding an urgent dental matter. The member conveyed the concern to the Data Telesis representative and was advised to expect a call from a dentist within an hour. In the member's complaint, the member stated that she never received a return phone call. The Plan's grievance coordinator documented in the case notes that the Access Dental Center manager stated, "need meeting with DT . . . DT does not let us know that member has been calling."

Rule 1300.67.2.2 (c)(9) and the Plan's Provider Manual require providers to employ an answering service or a telephone answering machine during non-business hours, which provide instructions regarding how members may obtain urgent or emergency care including, when applicable, how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care. In addition, Rule 1300.70(a)(3) requires that the Plan's "QA program must address service elements, including accessibility, availability, and continuity of care." Although the Plan does not directly contract with Data Telesis, it is responsible for ensuring that members with after-hours emergencies receive timely care. Therefore, the Plan should ensure that the Access Dental Centers are appropriately monitoring their contracted after-hours telephone line for compliance. Failure to address Data Telesis's nonresponse to a member can result in a violation of Rule 1300.70(a)(3).

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<sup>9</sup> Data Telesis, a Chennai, India based company founded in 2002. Data Telesis provides administrative services such as: claim processing, data entry, comprehensive accounting functions including accounts payable, accounts receivable, consolidation of information, commission calculations and financial analysis, collection services, telephone member services, enrollment services, dental billing services and payroll and human resources tasks

**Process or System Issues that Should Be Addressed:** The Plan should ensure that the lines of communication between members requesting after-hours emergent care with Data Telesis are handled appropriately.

**Plan's Response to Identified Recommendation:** The Plan's response stated that the Plan currently handles after-hours urgent and emergency calls internally and that the function is no longer handled by Data Telesis. The Access Dental Centers have contracted the after-hour processing of the calls to a local call center company that specializes in health provider facilities. The call center company has access to dental providers practicing at Access Dental Centers and is able to reach them by contacting the providers through cell phone numbers designated to each facility. At each Access Dental Center, providers carry the designated cell phone for after-hours services on a rotational basis.

In addition, the Plan's response provided that ongoing performance monitoring by the Plan is conducted in accordance with the Plan's newly revised policy which will be presented during the Plan's 4<sup>th</sup> quarter quality management committee for approval. The policy will be implemented upon State approval.

### **SECTION III: DISCUSSION CONTRACT FINDINGS AND CURRENT STATUS**

The Department's review identified specific Contract Findings in particular survey areas. The Plan was required to review and evaluate the Department's findings and provide corrective action within 45 days of the issuance of the Preliminary Report. The following discussion summarizes the Plan's compliance effort and the Department's finding concerning the Plan's response.

The Department identified **three** Contract Findings.

#### **MEMBER EDUCATION**

**Contract Finding #1: During the review period, the Plan did not have a Member Education policy that meets the DHCS GMC Member Education requirements.**

**Contract Reference(s):** DHCS GMC Contract 07-65802 Exhibit A, Attachment 10, Item 7

**Assessment:** The Plan's Member Education Policy QM-15 states, "To describe methods of providing educational and informational materials to Access Dental Plan members, to ensure their understanding of benefits, rights and responsibilities, and to encourage/ promote improved oral hygiene and prevent dental disease." The Plan's policy also provides that the Plan participates in health fairs to inform the community of current dental practices and standards. A review of the Plan's Evidence of Coverage for GMC members showed that the Plan encourages members to take advantage of school Dental Education Programs.

The Department's review found that the Plan does not have a formal documented policy or Health Education Program specific to its Medi-Cal population that describes how the Plan meets the educational requirements provided for in the DHCS GMC Contract. During the review period, the Plan provided education material to members upon enrollment, through on-going correspondence, through newsletters and brochures and at community health fairs. However, onsite staff interviews revealed that until recently, the Plan did not have a robust GMC Member Education Program nor did the Plan conduct evaluation on educational programs directed at the GMC enrollee membership.

The DHCS GMC Contract, Exhibit A, Attachment 10, Scope of Services, Item 7, requires that the Plan implement and maintain a dental health education system that provides the organized programs, services, functions, and resources necessary to deliver dental health education, dental health promotion and patient education to assist members in improving their dental health and manage dental disease. Further, contracted plans are required to adopt and maintain appropriate Dental Health Education Program standards or guidelines and policies and procedures, and conduct appropriate levels of evaluation, e.g. formative, process, impact, and outcome evaluation, to ensure access, availability, and effectiveness in achieving Dental Health Education Program goals and objectives. The Plan must also maintain documentation that demonstrates effective implementation of all DHCS health education requirements under the contract.

**Processes or Systems that Need to be Addressed:** The Plan should revise its educational policy to ensure that it meets all of the requirements provided for in the Member Education section of the DHCS GMC Contract and that it is actively implementing and evaluating the program.

**Plan's Compliance Effort:** The Plan's submitted response stated that the Plan maintains a comprehensive Dental Health Education Program and provides continuous education to providers and members to ensure understanding of the Plan's process, Plan benefits, preventative dental care and managed care principles through a variety of health education processes for beneficiaries and their families, contracted dental providers, community stakeholders, and the Plan's staff.

The Plan stated that it provides necessary and required informational materials about the Plan during enrollment, and updates members as changes occur. The Plan provided a list of educational activities that it believes meet the DHCS GMC Contract requirements. The following is a list of educational activities provided by the Plan:

- Members receive initial orientation upon enrollment, and ongoing education through correspondence, newsletters and educational brochures.
- Member Orientation Packets include specific information explaining:
  - Authorization procedures;
  - Accessibility policies;
  - Benefit coverage and limitations (EOC);
  - Member Rights and Responsibilities;
  - Standards for appointment wait times; and
  - Other information that assists the member with understanding the Plan and accessing dental services.

The Plan further explained that the welcome letter that is mailed with the EOC and ID card to all GMC members when they become enrolled with the Plan advises each new member that good oral health is essential for their overall well-being, and encourages them to visit the dentist at least annually for a professional cleaning and exam. The Plan also informs members to start their dental visits at an early age to help them with strong, healthy teeth while building good dental habits.

In addition, the Plan stated that it mails reminder cards for GMC members who have not seen their Primary Care Dentist within 90 days of their enrollment to the program. The reminder cards have different educational topics related to gum disease, development of child's teeth, sealant, brushing and flossing and thumb sucking. The Plan also has a Web site that is available to all members.

The Plan provided a copy of new policies *E.D. 001.01 Member and Provider Education \_Access to care and E.d.002.01 Dental Health Education Systems* that will be presented at the 4<sup>th</sup> quarter Quality Minute Committee for review and approval. The policies will be implemented upon approval from the State.

### **Department's Finding Concerning Plan's Compliance Effort:**

#### **STATUS: NOT CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this Contract Finding has not been fully corrected.

The Department finds that the Plan has attempted to correct this Contract Finding by implementing new policies and procedures that address the required elements of the DHCS GMC Contract. However, at this time, the Department cannot confirm that the Plan is actually conducting evaluation studies on the effectiveness of the Plan's Member Education Program nor that the Plan is documenting effective implementation of the Member Education Program. Therefore, this contract finding will require follow-up review.

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**Contract Finding #2: The Plan does not ensure that all written member information is provided to members at the sixth-grade reading level.**

**Contract Reference(s):** DHCS GMC Contract 07-65802, Exhibit A, Attachment 13, Item 4-C.

**Assessment:** The Department reviewed informational material provided by the Plan to GM C members in order to determine whether the material was written at a sixth-grade reading level as required by the DHCS Contract. The review showed that the Plan's Utilization Management Letter Template and the Evidence of Coverage provided to members ranged from an eleventh-grade reading level to a nineteenth-grade reading level.

**Process or Systems that Need to be Addressed:** The Plan should ensure that written materials provided to GMC members are written at a sixth-grade reading level. Providing members with information that is clear and understandable enables members to make informed dental care decisions.

**Plan's Compliance Effort:** The Plan stated that it understands that it is obligated under contract to ensure that all written member material is provided at a sixth-grade reading level. The Plan's response provided that it would review written member information and revise it to fall within acceptable reading levels. The Plan has developed a new policy and procedure titled Readability, Literacy and Alternative Formats, which will be presented during the 4<sup>th</sup> quarter Quality Management Committee meeting for review and approval. The Plan provided a copy of the new policy.

### **Department's Finding Concerning Plan's Compliance Effort:**

#### **STATUS: NOT CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this Contract Finding has not been fully corrected.



The Plan submitted evidence showing the revision of written material provided to GMC members. Specifically, the Department's review found that the Plan's Utilization Management Letter Template submitted to the Department, as part of this correction action plan, did not meet the sixth-grade reading level requirement.

The Plan stated that it is currently revising its Evidence of Coverage (EOC) for submission to the DHCS in January of 2013 as part of the renewal of the Plan's contract with DHCS.

The Department will conduct follow-up review to determine compliance with this contract requirement.

## CULTURE AND LINGUISTICS

**Contract Finding #3: The Plan's Language Assistance Policy and Procedure explicitly excludes Medi-Cal enrollees and does not explain what Language Assistance services are available for Medi-Cal members.**

**Contract Reference(s):** DHCS GMC Contract 07-65802, Exhibit A, Attachment 9, Item 13.

**Assessment:** The Department's review included an assessment of how the Plan provides Language Assistance to non-English or limited-English speaking GMC members. The Plan has two instructional documents where it explains its language assistance policies and processes. The Plan's Provider Manual and its Quality Management Policy and Procedure # AA-05 contains language that specifically excludes Medi-Cal members. The Plan's Procedure # AA-05 states, "language assistance policies and procedures will not apply to Medi-Cal enrollees." The Plan's Provider Manual states "A description of the language assistance services for non-Medi-Cal members."

The DHCS GMC Contract requires that the Plan ensure equal access to dental care services for limited English proficient members through provision of high quality interpreter and linguistic services. Although Plan representatives stated that both documents do apply to Medi-Cal members, the language in both documents specifically excludes the Plan's Medi-Cal product line. The Department's review did not indicate that the Plan had another written language assistance policy specific to GMC members.

**Process or Systems that Need to be Addressed:** The Plan should revise both the Provider Manual and the Language Assistance Policy to specifically include GMC members or create a new policy for GMC members.

**Plan's Compliance Effort:** The Plan stated that in an effort to standardize the Plan's process for adhering to the Language Assistance Program for all programs it offers, the Plan has revised the language assistance policy and has removed the exception language excluding the Plan's Medi-Cal product line. The Plan provided that the removal of the language will ensure that providers and staff follow the same guideline for all of the Plan's programs. Further, providers will not be confused as to what language assistance services are available for the Plan's GMC members.

**Department's Finding Concerning Plan's Compliance Effort:**

**STATUS: CORRECTED**

Based upon the corrective actions undertaken, the Department has determined that this Contract Finding has been fully corrected.

The Department reviewed the Plan's submission of the newly revised referral form and provider manual. In addition, the Department reviewed the Plan's new language assistance policy and procedure and found that the Plan removed the exclusionary language and has added language that includes GMC members.

## SECTION IV: SURVEY CONCLUSION

In the event the Plan would like to append a brief statement to the Final Report as set forth in Section 1380(h)(5), please submit the response via the Department's Web portal, eFiling application. Click on the Department's Web Portal, [DMHC Web Portal](#)

Once logged in, follow the steps shown below to submit the Plan's response to the Final Report:

- Click the "eFiling" link.
- Click the "Online Forms" link
- Under Existing Online Forms, click the "Details" link for the **DPS Routine Survey Document Request** titled, **2012 Routine Dental Survey - Document Request**.
- Submit the response to the Final Report via the "DMHC Communication" tab.